

Requester: Fill Out to Receive Requested  
Information Expeditiously.

Notify:

Supervisor

Location:

SAIL Dept.

**NOTE:** THIS FORM IS TO BE USED TO **OBTAIN** MEDICAL RECORD INFORMATION **FROM** OTHER AGENCIES.

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I hereby request and authorize: \_\_\_\_\_

to release information to: Milwaukee County Behavioral Health Division  
9455 Watertown Plank Road  
Milwaukee, WI 53226

The purpose for releasing these records is \_\_\_\_\_

I understand that the information may include diagnosis, prognosis, and/or treatment for physical illness, mental disorders, alcohol or drug abuse, any HIV test results and/or AIDS-related diagnosis.

The specific and relevant information I wish to release is:

\_\_\_\_\_ Discharge Summaries

\_\_\_\_\_ Treatment Plans

\_\_\_\_\_ PCS Intake

\_\_\_\_\_ Lab/Radiology

\_\_\_\_\_ History & Physical

\_\_\_\_\_ Outpatient Assessments/Evaluations

\_\_\_\_\_ Psychiatric/Psychological Evaluations

\_\_\_\_\_ Outpatient Progress Notes/Treatment Plans

\_\_\_\_\_ Social Service Data Bases

\_\_\_\_\_ Other (specify) \_\_\_\_\_

for the treatment period of (list approximate dates): \_\_\_\_\_

I understand that I may revoke this consent at any time by written notification except to the extent that action has been taken in reliance on it, and that in any event, this consent will expire one year from the date of signature unless an otherwise stated date, event or condition is stated here

A photocopy or facsimile of this authorization shall be as valid as the original.

**PROHIBITION ON DISCLOSURE** (for Alcohol and Drug Abuse records): This information is protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient. I also understand that I may inspect and, upon payment of the usual fee, receive a copy of the released information, and that I may receive a copy of this intended consent form.

**Conditions:** This authorization is voluntary. BHD will not condition your treatment on this authorization.

**Effect of Granting This Authorization:** The protected health information described above may be disclosed and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

Signature of Patient \_\_\_\_\_

Person Authorized To Consent For Patient \_\_\_\_\_

Date \_\_\_\_\_

Date: \_\_\_\_\_

Witness \_\_\_\_\_

Relationship \_\_\_\_\_

(Legal documentation of relationship required)

Reason: \_\_\_\_\_

BEHAVIORAL HEALTH DIVISION  
Milwaukee, Wisconsin 53226

**NOTE:** THIS FORM IS TO BE USED TO **RELEASE** MEDICAL RECORD INFORMATION **FROM** THE BEHAVIORAL HEALTH DIVISION

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I hereby request and authorize: Milwaukee County Behavioral Health Division  
9455 Watertown Plank Road  
Milwaukee, WI 53226

/SAIL

to release information to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The purpose for releasing these records is \_\_\_\_\_

I understand that the information may include diagnosis, prognosis, and/or treatment for physical illness, mental disorders, alcohol or drug abuse, any HIV test results and/or AIDS-related diagnosis.

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\_\_\_\_\_ Other (specify) \_\_\_\_\_

for the treatment period of (list approximate dates): \_\_\_\_\_

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\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Person Authorized To Consent For Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Witness

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Relationship

(Legal documentation of relationship required)

\_\_\_\_\_  
Reason:

BEHAVIORAL HEALTH DIVISION  
Milwaukee, Wisconsin 53226